

The following questions must be completed for HIV-1/HIV-2 Testing:

TYPE OF TUBE USED FOR BLOOD DRAW

| | |
|----|---|
| 22 | <input type="checkbox"/> Clot tube (red-top for serum) <input type="checkbox"/> SST tube (red and gray tiger top tube – for serum) <input type="checkbox"/> Other (specify) _____ |
|----|---|

DATE OF CENTRIFUGATION

TIME OF CENTRIFUGATION

| | | | | | | | | | | | | | | | |
|----|---|---|---|---|---|---|---|---|----|--|--|--|--|--------------------------------|--------------------------------|
| 23 | M | M | D | D | Y | Y | Y | Y | 24 | | | | | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
|----|---|---|---|---|---|---|---|---|----|--|--|--|--|--------------------------------|--------------------------------|

DATE OF POURING OFF (SERUM)

TIME OF POURING OFF (SERUM)

| | | | | | | | | | | | | | | | |
|----|---|---|---|---|---|---|---|---|----|--|--|--|--|--------------------------------|--------------------------------|
| 25 | M | M | D | D | Y | Y | Y | Y | 26 | | | | | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
|----|---|---|---|---|---|---|---|---|----|--|--|--|--|--------------------------------|--------------------------------|

TOTAL VOLUME OF SERUM SENT FOR HIV TESTING

| | |
|----|------------------|
| 27 | _____ . _____ mL |
|----|------------------|

SERUM CONDITION

| | |
|----|--|
| 28 | <input type="checkbox"/> No Hemolysis <input type="checkbox"/> Low Hemolysis <input type="checkbox"/> Moderate Hemolysis <input type="checkbox"/> High Hemolysis <input type="checkbox"/> Lipemic <input type="checkbox"/> Contaminated |
|----|--|

DATE OF COURIER PICK UP

TIME OF COURIER PICK UP

| | | | | | | | | | | | | | | | |
|----|---|---|---|---|---|---|---|---|----|--|--|--|--|--------------------------------|--------------------------------|
| 29 | M | M | D | D | Y | Y | Y | Y | 30 | | | | | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
|----|---|---|---|---|---|---|---|---|----|--|--|--|--|--------------------------------|--------------------------------|

IF APPLICABLE:

DATE SAMPLE FROZEN AT -70 CELCIUS

TIME SAMPLE FROZEN AT -70 CELCIUS

| | | | | | | | | | | | | | | | |
|----|---|---|---|---|---|---|---|---|----|--|--|--|--|--------------------------------|--------------------------------|
| 31 | M | M | D | D | Y | Y | Y | Y | 32 | | | | | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
|----|---|---|---|---|---|---|---|---|----|--|--|--|--|--------------------------------|--------------------------------|

SAMPLE KNOWN TO BE INELIGIBLE FOR GENOTYPE TESTING - EXPLANATION

| | |
|----|--|
| 33 | |
|----|--|

Sexually Transmitted Diseases – Definitions

- Symptoms:** Patient requesting examination due to symptoms, or, symptoms discovered on examination.
- Infected Partner:** Patient has known exposure to STD (self-reported or documented).
- Partner Risk:** Patient has multiple sex partners.
- History of STD:** Patient has been diagnosed with a sexually transmitted disease within last 3 years.
- Prenatal Visit:** Patient examination is part of prenatal visit.
- Age recommended:** Recommended age criteria for screening female patients is ≤ 24 for family planning clinics, adolescent and juvenile detention sites, and all ages for STD clinics.
- “Plan First!” Clients:** A “Plan First!” client seeking family planning services will receive screening and teaching. *Chlamydia trachomatis* and *Neisseria gonorrhoeae* screening must be offered to “Plan First!” clients < 24 years of age, prior to provision of a contraceptive method, if risk factors are reported.
- IUD Insertion:** Title X mandates that clients who are provided with Intrauterine Device (IUD) insertion must be tested for *N. gonorrhoea* and *Chlamydia trachomatis* for diagnostic purposes and/or for maintenance of health status.

¹All tests positive for *Chlamydia* will automatically be tested for *N. gonorrhoeae*.